

# How and why nurses' direction and delegation skills should be improved

A recent study has highlighted the need for greater clarity about the skills needed for successful direction and delegation interactions between nurses.



A non-hierarchical approach is needed to form good delegation relationships.

By Margaret Hughes, Ray Kirk and Alison Dixon

**D**irection and delegation is a professional competency required by all New Zealand nurses registered with the Nursing Council. The registered and enrolled nurses' scopes of practice and their respective competencies make this very clear.<sup>1,2,3,4</sup>

With the reintroduction of the enrolled nursing training programme in 2004, and a revised and broadened enrolled nurse (EN) scope of practice in 2010,<sup>1</sup> new inexperienced ENs, as well as experienced ENs, required direction and delegation. Many registered nurses (RNs) had not worked with ENs, as New Zealand had moved to an RN-only workforce over the years preceding 2010, and some of the RNs were themselves new and inexperienced. Nurses in clinical workplace

settings and nursing students knew they were required to direct and delegate, or be directed and delegated to,<sup>2,3,4</sup> but struggled to know how to carry out this professional competency.

## Communication skills needed

A six-year study of how RNs and ENs communicated with each other during direction and delegation was completed this year. The study, which included 36 RNs and ENs from the Canterbury region, accessed the nurses' perspectives on the direction and delegation interactions they had been involved in. It found that comprehensive assessments, an advanced understanding of communicating, and the leadership role nurses played – and had access to – influenced the success or not of direction and delegation interactions.

RNs and ENs in the study all described the assessment skills RNs required. Assessment included not just an as-

essment of the patient, the task, the context of care and the EN knowledge, skill and experience,<sup>4</sup> but the way the EN assessment occurred. All nurses said this assessment needed to be a "conversation", "negotiated", "tactful" and "diplomatic".

## Confusion about EN scope

However, most RNs and ENs reported confusion surrounding the different EN levels and how the resultant restrictions on an EN's scope of practice influenced what they could and could not do. The confusion was amplified because many RNs were confused about what an EN could do in any one specific workplace, as this differed from one nursing workplace to another. Assessing an EN required time, knowledge of the EN scope of practice and courtesy, which was not always apparent.

ENs also needed robust assessment skills, with self-assessment emerging as an important strategy to keep themselves, their registration and their patients safe. Self-assessment, as a safety mechanism, involved the EN deciding if they had been trained to do a task, or felt confident to do it. If the EN did not feel confident after self-assessing, they could decline to do a task. This became problematic if the RN did not understand this was an essential part of the delegation relationship. The EN could also decline to do a task if s/he had been moved to an unfamiliar area due to under or overstaffing, where they were expected to function at a top level in a setting they did not know well.

Nearly all the nurses in the study identified that, while RNs needed to take on a leadership role in the team, some RNs were reluctant to lead because delegation was time-consuming, they were confused about how to do it, or they could not find the information about what the EN could and could not do. They also described situations where many RNs could "delegate", which really

meant allocating many tasks, to one EN. Conversely, some ENs described situations where they could not get delegation or direction from the RN because of the model of nursing care selected, or they had to work hard to constantly ask for, or request, delegation instructions from an RN.

### Nursing leadership needed

The need for nurse-leaders was identified by both RNs and ENs. All study participants requested nurse-leaders – defined as those nurses who had the authority to lead and develop practice and who were responsible for service delivery<sub>s</sub> – to make changes to the nursing model so they could work *in* a team, not just *as* a team. In some workplaces, ENs described working in a geographical or primary model of nursing. This was counterproductive to establishing the delegation relationship needed to make delegation interactions work.

Both RNs and ENs asked for nurse-leaders who could facilitate the area-specific information, advice and policy guidance about direction and delegation, and information about the different responsibilities ENs had in different workplaces. For three of the nurses, the lack of information about the delegation role, and confusion surrounding what an EN could do, had had a tragic impact on patient safety and dignity. One result of this was that two further nurses decided not to continue in their nursing positions.

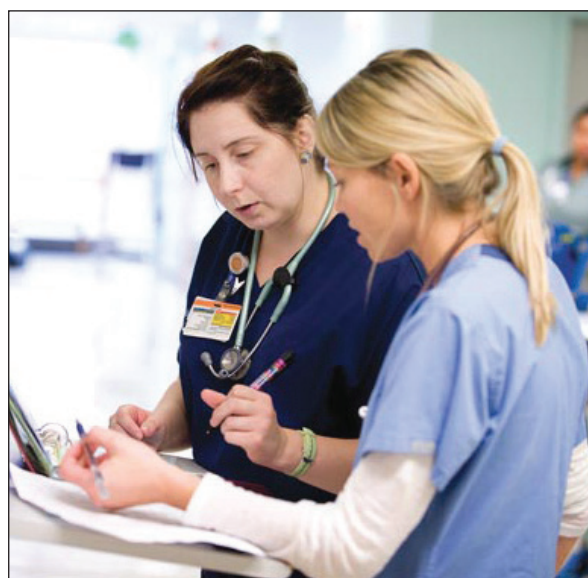
ENs identified the barriers to delega-

tasks to the EN. This was almost impossible when the RN was new.

Overall, communication strategies, skills and attributes underscored all the nurses' stories about their direction and delegation interactions. Both RNs and ENs acknowledged that good delegation required a sophisticated range of communication strategies, and this way of communicating took time. The skills these nurses revealed in their individual stories of direction and delegation were required for assessment and leadership roles and responsibilities.

### Working together

Six of the experienced ENs spoke of the need to "work together". Their perception was that it was better to work "alongside", not "under" the RN. They wanted to work together with RNs who were "straight up", "tactful and diplomatic", were "mindful of the way a thing was said and how humour was used" and it was important to "get along with others". An RN who could "decode" what the EN was saying when they reported back to the RN contributed to working together. RNs who were "empathetic and kind" and "valued the contribu-



Advanced communication strategies include negotiation and collaboration.

amples of the RNs' ability to role model the required communication skills. For delegation interactions to work well, one experienced RN pointed to the need for increased access to education about delegation. She described how there were sometimes unwritten rules of delegation in different workplaces. Throughout the RNs' stories, the requirement to be "approachable", "polite", "honest", "kind" and not accept or tolerate poor communication were listed as important strategies to support working as a team. This might mean RNs needed to be prepared to accept feedback on their delegation style.

While all the ENs identified the role of good communication, for four experienced ENs, it was woven throughout all their stories. Communicating well was captured as health-care professionals being aware of the "tone", a "soft delivery", "being listened to", an RN who could provide leadership and assess the EN in a respectful way and who knew and used the strengths and personalities within the team. The ENs identified that basic communication skills such as the RN saying "thank you" at the end of the shift, "being welcomed" onto the ward, and a "balanced and egalitarian approach" were required if nurses wanted to communicate well during delegation.

Just as the ENs' stories were threaded with the need for communication skills and the strategies they used during

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tion when they were required to follow the leadership of a new inexperienced RN – someone who did not yet hold the workplace-specific clinical knowledge required to delegate safely. Although they were sympathetic to a new RN on the ward, this inexperience highlighted the need for RNs to have area-specific clinical knowledge about a specialised workplace, and to be able to safely delegate

tion of the EN" and could "share their knowledge" helped RNs and ENs to work together. There was no place for RNs who were "unfair in the workload allocation", or who "lorded it over" others.

Two experienced and one inexperienced RN championed working in a team nursing model and working together. Their experiences of delegation interactions were bound together with ex-

direction or delegation, so too were the RNs' experiences. Four RNs described "good" communication skills such as "being fair", "being open", "being inclusive", "listening well", "having empathy" and monitoring how something was said. They also talked about their perceptions that they were expected to know how to delegate by "osmosis". The information they believed they needed to make delegation work was missing. One RN explained that, as listeners, it was important to go "beyond, beneath and behind" what people were saying, ie understanding why a nurse said what she said, and did what she did, was vital to safe and effective direction and delegation communication interactions between RNs and ENs.

### More than giving instructions

Three experienced and one inexperienced EN identified that delegation was more than giving a set of instructions, and required taking the time needed for sensitive communication, robust assessments skills and leadership. When these were absent, delegation interactions were characterised by under-involvement. Conversely, when delegation interaction was micro-managed, this felt like over-involvement. Getting the balance right, so a delegation relationship could form, required "the ENs being a valued part of the team and the decision-making", "dialogue and negotiation", an "RN who listened" and "a non-hierarchical approach". One EN described her delegation interactions as an "inverted hierarchy" where many RNs could delegate numerous tasks to her but she did not know who to report to. Unfair workloads and a lack of support for the new and inexperienced EN undermined any chance of a relationship forming.

Two inexperienced and one experienced EN found they constantly had to "seek" or "extract" a direction or delegation interaction with an RN. The ENs knew and understood they must work under RN direction and delegation and worked hard to ensure they did this. Seeking or extracting delegation was a balancing act – while they understood the RN was busy, there was also a degree of urgency for the patients the EN was caring for. This required "polite and

respectful communication", "common courtesy" and an RN who knew about the EN scope of practice and, importantly, the delegation role. It also required advanced communication strategies such as "negotiation", "collaboration", "ENs who respected the RNs' knowledge and experience" and, for one EN, allowing the RN to "save face" if incorrect information was given to them.

Two experienced and two inexperienced RNs described how they chose to use a number of advanced communication strategies to meet the direction and delegation requirement of their scope of practice, and to keep everyone involved, safe. For one RN, her ability to communicate and share information with others in her team, enabled her to "create lieutenants". These nurses would carry out her delegated tasks when she was busy in another part of the workplace. For a new and inexperienced RN, the confusion around the roles and responsibilities of this professional obligation resulted in her not doing delegation at

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all, as it "would not be tolerated" in her workplace. However, for those RNs who did delegate, the ability to "read between the lines when interacting with ENs", "making time for the EN" and having an inclusive plan of care by using a template or grid to guide the allocation of tasks at the beginning of shift, were important communication skills to "doing" delegation well.

Five experienced RNs discussed the delegation skills they believed RNs and

ENs needed to ensure they had safe and effective delegation interactions. RNs needed planning and preparation, tact and diplomacy to carry out a (mini) assessment of the EN. The EN also needed time, consideration and space to self-assess. The key to bringing the communication and assessments together was leadership. These skills could almost be taken for granted by those involved, and could be invisible to the uninitiated onlooker. This knowledge was not inherently known and needed experience, commitment and senior nursing leadership support to develop.

### Summary

The research study, completed in 2017, has provided a library of preferred communication strategies to support safe and effective direction and delegation communication interactions for New Zealand nurses. While some seem obvious and are an expected part of our everyday interactions, the stories gathered from the 36 RNs and ENs showed these were not always practised. There are new findings, too, such as the degree of confusion about both direction and delegation roles and responsibilities, requests from both RNs and ENs for more leadership in the team model of nursing care, and more direction, delegation and accountability information. Local area policy and advice about the roles and responsibilities of ENs, relevant to their practice area, were also needed. Overall, the lack of information resulted in confusion. This had an impact on direction or delegation communication interactions. More concerning, it could affect patient safety and nursing staff retention. •

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